MetLife®
Metropolitan Life Insurance Company, New York, NY

DENTAL ENROLLMENT/CHANGE FORM FOR EDUCATIONAL BENEFIT COOPERATIVE

SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer (Please Print) Educational Benefit Cooperative		Group Report No. 303341	Sub Division	Branch
Employer's Street Address	City	State	Zip Code	Employee Work Location
Date of Hire (Mo./Day/Yr.)		Coverage Effective Date (Mo./Day/Yr.):		
Work Status: ☐ New Hire ☐ Active ☐ Retired ☐ Disabled ☐ Rehire ☐ On Layoff/Leave of Absence		Hours Worked Per Week:	☐ Hourly Paid ☐ Salaried	☐ Full-Time ☐ Part-Time
☐ Original COBRA Effective Date (Mo./Day/Yr.)_____				
Reason for Enrollment: ☐ New Coverage ☐ New Hire First Time Eligible ☐ Change in Enrollment ☐ Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____				

SECTION TO BE COMPLETED BY EMPLOYEE

Name (print) First Middle Last	Social Security No.	Date of Birth (Mo./Day/Yr.)	☐ Male ☐ Female
Address Street City	State Zip Code	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
E-mail Address		Phone No. (include area code)	

COVERAGE REQUEST DATA:

I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits which I am or may become eligible, requested below.

I request the following coverage:

Employee Coverage

☐ Dental

Dependent Spouse/Child Coverage

☐ Spouse Only ☐ Spouse + Children

☐ Children Only ☐ Employee + One Dependent

If applying for Dependent coverage (Spouse and Child), complete section below:

Number of dependents (including spouse)

Name (Last, First, MI)	Date of Birth	Sex (M/F)
Spouse:		
Child(ren):		

If dependent children are full-time students in college, vocational or trade school, please complete the following:

Child(ren)	Name of School

Please Retain A Copy Of The Fully-Completed Form For Your Records And Return The Original To Your Employer

DECLARATION SECTION

Each person signing below declares that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief.

The employee declares that he or she is actively at work on the date of this enrollment form

For Changes Requested After Initial Enrollment Period Expires

I understand that if dental coverage is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

For Payroll Deduction Authorization By the Employee

I authorize my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Kansas and Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

In any other case, read the following warning.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature(s): The employee must sign in all cases. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Employee Signature	Print Name	Date (Mo./Day/Yr.)